

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

=62-049426

STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No. 128

Primary Registration District No. 2000

Registrar's No. 1929B

FILED JAN 23 1963

VS 300
Rev. 4/59

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY GREENE		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY CHRISTIAN	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN SPRINGFIELD		c. CITY OR TOWN NIXA	
Length of stay in 1b 1 DAY		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION ST. JOHN'S HOSPITAL		d. STREET ADDRESS (If outside, give location) NIXA	
Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last LACO E. KELTNER		4. DATE OF DEATH Month Day Year DEC. 29, 1962	
5. SEX MALE	6. COLOR OR RACE WHITE	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 12/24/91
9. AGE (last birthday) 71		10. IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED--CITY UTILITIES		10b. KIND OF BUSINESS OR INDUSTRY ASH GROVE, MO.	
11. BIRTHPLACE (City and state or country) USA		12. CITIZEN OF WHAT COUNTRY USA	
13a. FATHER'S NAME MARION F. KELTNER		13b. MOTHER'S MAIDEN NAME DELLA JANE KERR	
14. NAME OF HUSBAND OR WIFE RUBY KELTNER			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. [REDACTED]	
17. INFORMANT MRS. RUBY KELTNER; NIXA, MISSOURI		Address	
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ARTERIOSCLEROTIC HEART DISEASE		INTERVAL BETWEEN ONSET AND DEATH SEVERAL YEARS	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year			
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION	COUNTY STATE
21. I attended the deceased from 1-11-57 to 12/29/62 and last saw her him alive on 12/29/62 Death occurred at 5:40 P. m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE Allen O. T. [Signature] (Degree or title) DR. ALLEN O. T. [Signature], M.D.		22b. ADDRESS SPRINGFIELD, MO.	
22c. DATE SIGNED 1-21-63			
23a. BURIAL CREMATION, REMOVAL (Specify) BURIAL	23b. DATE 1/1/63	23c. NAME OF CEMETERY OR CREMATORY PAYNE CEMETERY	23d. LOCATION (City, town, or county) (State) CHRISTIAN COUNTY, MO.
24. FUNERAL DIRECTOR AYRE-GOODWIN		25. DATE RECD. BY LOCAL REG. 1-22-63	
26. REGISTRAR'S SIGNATURE Effie S. Melton			

JAN 28 1963

Permit 13-31-63

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,

or by _____

Student Embalmer No. _____

working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed _____

Licensed Embalmer No. 5136

P. O. Address Springfield, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.